

CMO's Update 35

A communication to all doctors from the Chief Medical Officer

Contingency plans for smallpox

January 2003

Currently there is no evidence of a specific or immediate threat of smallpox to the UK. However, as the public health consequences would be severe, it is essential that contingency plans are available nationally and locally should smallpox re-emerge.

be unfamiliar with this transmissible disease. In addition, immunity in the population will not have been maintained, and early detection and a rapid public health response will be vital to control spread of disease.

Key elements of the plan are:

- the establishment of rapid response teams
- the prompt isolation of confirmed or suspected cases
- the tracing and vaccination of patient contacts
- the training of health care professionals
- the use of graded alert levels, which would prompt specific actions.

Twelve Smallpox Response Groups are being established around the UK, comprising specialists to respond to and manage the initial stages of a smallpox incident.

Members of the teams are being protected by vaccination in advance, to allow them to react quickly and work safely with patients with actual or suspected smallpox. The vaccination of these workers is now underway.

Isolation of cases and effective identification, tracing, vaccination and monitoring of contacts is essential to prevent the spread of infection. Any delay in intervention is likely to have a significant impact on the scale of the outbreak. Procedures for management of cases and contacts are summarised in the plan.

Training key clinical staff in the recognition and management of disease is of paramount

Full preparations are now underway to deal with any potential threat, as part of the Department of Health's on-going national contingency plans for responding to deliberate release of chemical, radiological or biological agents.

There are three components to the range of measures taken for the response to a possible smallpox emergency:

- a plan of action
- improved vaccine stocks
- a cohort of immunised staff who could deal safely with any potential smallpox cases.

An interim guidance plan for discussion and comment was published in early December. This outlines the strategies and approaches that would guide national and local responses to a smallpox emergency. Based on the *Memorandum on the Control of Outbreaks of Smallpox* (1975) and in line with current World Health Organisation advice, it recommends a "search and contain" strategy.

Action has been taken to substantially increase stocks of smallpox vaccine and a second procurement exercise has begun, to add to these stocks.

Following the world-wide eradication of smallpox in 1980, many healthcare professionals and the general public will

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Chief Medical Officer's website



www.doh.gov.uk/cmo

Contingency plans for smallpox *continued*

importance. Training for infectious disease physicians and public health physicians has commenced and training for A&E consultants, GPs and laboratory staff will commence in the near future. Information packs for healthcare workers and the general public are also being developed.

Wider vaccination is not recommended as in the absence of a specific threat, the side effects outweigh the advantages. Vaccination of the teams is voluntary and they are being carefully screened for contra-indications such as immunodeficiency, history of eczema or pregnancy.

These plans are a practical precaution designed to ensure the UK is prepared for any possible smallpox emergency and will be kept under active review.

The Interim Guidelines for Smallpox Response and Management in the Post-Eradication era is available at: www.doh.gov.uk/epcu/cbr/biol/smallpoxplan.htm. Clinical images can be found on the PHLS website: www.phls.co.uk

General planning guidance documents *Planning for Major Incidents: The NHS Guidance (1998)* and *Deliberate Release of Biological and Chemical Agents – Guidance to help plan the health service response* together with information about other terrorism agents are available at: www.doh.gov.uk/epcu/cbr/intro.htm.

Contact: Dr Mark Evans, Room 638B, Department of Health, Skipton House, London SE1 6LH. mark.evans@doh.gsi.gov.uk.

HEALTH PROTECTION

Health clearance for new health care workers – guidance for consultation

New guidance on health clearance measures for serious communicable diseases, for health care workers starting work in the NHS, was published for consultation on 2 January 2003. The groups of health care workers who will be most affected are those performing exposure prone procedures (typically invasive procedures in surgery, dentistry and midwifery).

The new measures are based on the recommendations of an expert group set up to assess the risk to patients from new health care workers infected with serious communicable diseases (HIV, hepatitis B, hepatitis C and tuberculosis). The purpose of the checks is not to stop health care workers infected with blood-borne viruses from working in the NHS, but to restrict them from those clinical areas where their infection may pose a risk to patients.

The expert group's report and the draft guidance for consultation can be found at <http://www.doh.gov.uk/healthclear>

Comments should be sent to healthclear@doh.gsi.gov.uk by 30 April 2003. Hard copies of the draft guidance may be requested from the NHS Response line 08701 555455.

Preventing accidental injury

'Preventing Accidental Injury – Priorities for Action', a report to the Chief Medical Officer by a cross-government Task Force, was launched on 11 October 2002 by the Public Health Minister Hazel Blears, with the support of Ministers responsible for road safety, fire prevention, home safety, health and safety at work, and sports safety.

The report identifies where efforts should be focused in future, and how they can have maximum impact through better planning, co-ordination and leadership; particularly with the support of public health practitioners. It sets a framework for delivering a significant contribution to the healthy and active lives of children and older people, identifying practical measures that can be applied now.

The report can be found at <http://www.doh.gov.uk/accidents>, or bought from The Stationery Office, PO Box 29, Norwich, NR3 1GN. For further information contact: Gbrown@doh.gsi.gov.uk.

Carbon monoxide: increased risk in winter

The risk of carbon monoxide (CO) poisoning indoors increases during winter¹.

While much attention is focused on gas appliances (used by over 20 million households), the risk of dying from carbon monoxide poisoning is actually greater in the two million households which rely on solid fuel.

Advice provided in the 2002 letter from CMO, 'Carbon Monoxide: the forgotten killer¹', is available at <http://www.doh.gov.uk/cmo/letters.htm>. Copies can also be obtained from Emma.Hellingsworth at Emma.Hellingsworth@doh.gsi.gov.uk

¹ Department of Health, 2002. Carbon Monoxide: the forgotten killer. (Professional Letter: PL/CMO/2002/2, PL/CNO/2002/2).

Tackling drug misuse in primary care

continued

- The National Treatment Agency's *Models of Care* – the new service framework for drug treatment.

Treatment is provided on the basis that drug dependency is a chronic relapsing condition, and includes both harm minimisation and abstinence-focused treatment. Primary care treatment, often in a shared care framework, is appropriate for many misusers who require long-term management of psycho-social factors alongside medical complications.

Testing for, and vaccination against, blood-borne viruses, informed advice and referral where appropriate, should be offered by all GPs. Detoxification, relapse prevention and maintenance may also be successfully provided in primary care. For chronic opiate dependence, substitute prescribing of methadone or buprenorphine is now widely accepted as

appropriate and effective. A key element of success is to ensure adequate dosage, with 60 to 120 mls of methadone being identified as a standard maintenance dose in the Department of Health's clinical guidelines (1999).

Further information

National Treatment Agency <http://www.nta.nhs.uk>,
GP training: <http://www.rcgp.org.uk> and www.smmgp.co.uk
Drug strategy:

<http://www.drugs.gov.uk/ReportsandPublications>
DH clinical guidelines

<http://www.doh.gov.uk/drugs/polguide.htm>,
GPs interested in establishing shared-care arrangements should contact their local Drug Action Team:
<http://www.drugscope.org.uk/dat/contacts.asp>,

For further information please contact Paul Hayes, Chief Executive, National Treatment Agency, Tel 020 79 72 2226, Nta.enquiries@nta.gsi.gov.uk

Cancer prevention resource launched

The Health Development Agency (HDA) has published a new resource to help health professionals implement the prevention aspects of the NHS Cancer Plan. 'Cancer Prevention: A resource to support local action in delivering the NHS Cancer Plan' is aimed at health professionals and staff working in Primary Care Trusts, Strategic Health Authorities, cancer networks and partner agencies, to assist in local strategic planning and delivery of initiatives to prevent cancer.

This resource will support healthcare staff and others in implementing evidence-based approaches to:

- reduce smoking
- increase physical activity levels
- reduce obesity
- improve diet and nutrition
- reduce alcohol consumption
- reduce sun exposure
- reduce radon exposure.

It includes links to a range of different organisations and websites.

The resource is free and is available on the HDA website <http://www.hda-online.org.uk> or by calling 0870 121 4194. *For more information contact: Stacey Adams, Health Development Agency, 020 7061 3115, Stacey.adams@hda-online.org.uk*

Evidence to support Teenage Pregnancy Strategy

The first cross-government Teenage Pregnancy Strategy was launched in 1999 with the objectives of halving the under 18 conception rates and reducing the social exclusion of young parents and their children. There are early signs that the Strategy is having a positive impact with a six per cent reduction in conception rates from the 1998 baseline.

Research shows that there is no simplistic solution to reducing teenage pregnancy rates. A multi-faceted approach appears to show most promise. A recent report from Unicef concludes that lowering teenage birth rates is a matter of giving young people both the 'means' and the 'motivation'. The Teenage Pregnancy Strategy is aiming to do this through a wide range of activities at national and local level. General Practitioners are young people's preferred source of contraceptive advice. The Royal College of General Practitioners (RCGP) is working closely with the Teenage Pregnancy Unit to provide training and resources to support GPs in making their practices more 'teenage friendly'.

Some critics have claimed that aspects of the strategy aimed at improving sex and relationship education and access to contraception, fail to reduce conception rates and increase sexual activity. The international evidence base from which the Strategy is drawn clearly refutes this. There is strong evidence for the effectiveness of sex and relationships education, when linked to contraceptive services; for community based education and contraceptive services; and for involving parents in prevention programmes. Evidence does not exist to suggest that abstinence approaches are effective. In addition, there is no reliable evidence that providing young people with sex and relationship information and contraceptive advice increases sexual activity.

More information on the Strategy and research briefing papers are on the Teenage Pregnancy Unit's website: <http://www.teenagepregnancyunit.gov.uk> and the leaflet *Getting It Right For Teenagers In Your Practice* is available from RCGP sales@rcgp.org.uk or 020 7581 3232. *For further information please contact Julie.Alexander@doh.gsi.gov.uk*

INEQUALITIES AND SOCIAL EXCLUSION

Cross-cutting review on health inequalities

The 2002 Cross-Cutting Review on Health Inequalities provided a unique opportunity to bring together different Government departments, local government and academic experts as part of the wider 2002 Spending Review exercise. The health inequalities review made recommendations on priorities for action and set out a long-term strategy across government for the implementation of the national health inequalities targets on life expectancy and infant mortality.

The importance of partnership and cross government working in tackling inequalities was emphasised throughout. The valuable work of NHS front line staff in tackling health inequalities, and potential to build on this in the new NHS structures, was also highlighted.

A summary report of the review is available at <http://www.doh.gov.uk/healthinequalities>. A delivery plan based on the recommendations of the review will be published in early 2003.

For further information please e-mail Anne Griffin at Anne.Griffin@doh.gsi.gov.uk

Reducing health inequalities – for people with learning disabilities

Health Action Plans (HAPs) and Health Facilitation are key elements of a strategy for addressing the health inequalities experienced by people with learning disabilities.

A Health Action Plan details the actions needed to maintain and improve the health of an individual and outlines any help needed to accomplish these. It may cover day-to-day issues such as diet, exercise, medicines, dental and optical care. It can also include more temporary plans to cover specific episodes such as hospital stays and subsequent care. GPs may be involved in developing HAPs and in ensuring that health improvement opportunities have not been missed.

Health Facilitation has been developed to help patients with learning disabilities access mainstream services and to help those services respond to their needs. Named contacts for each general practice will work alongside identified health facilitators for each PCT.

Good practice guidance on HAPs and health facilitation has been produced in three parts:

- a booklet for people with learning disabilities
- a detailed version to help those directly involved in implementation
- a summary version for Learning Disability Partnership Boards.

All versions and a flyer with details of where to obtain hard copies are available at <http://www.doh.gov.uk/publications/coinh.html> and at www.doh.gov.uk/learningdisabilities.

The guidance is part of a series of good practice guidance to support the implementation of the Government White Paper *Valuing People: A New Strategy for Learning Disability for the 21st Century*.

For further information please contact elaine.cooper@doh.gsi.gov.uk

Patient safety, medication error and handwriting

Medication error accounts for approximately a quarter of all incidents world-wide in which patients suffer avoidable harm.

The root causes of medication error are diverse. They include confusion over similar packaging and labelling, checking errors and misidentification of patients.

A cause of medication error that continues to occur regularly arises from misunderstanding or misinterpreting hand written prescriptions or instructions for the administration of medicines.

The Coroner of South Yorkshire (West) wrote to the Chief Medical Officer in the following terms about the death of a patient (the details of the incident including the patient's name are in the public domain having been subject to an inquest). The coroner wrote:

"Mr A died on the 28th June 2002 as a result of a gastro-intestinal haemorrhage. This event had been brought about by an excess of prescribed warfarin. It is the facts leading up to the accidental over-prescription of the warfarin which gives me concern as they could be repeated elsewhere.

Mr A had been on warfarin for a considerable period under the supervision of his GP. The monitoring system in place was that the practice nurse would visit Mr A one morning at his home to take a blood sample. This would be sent to the hospital for an INR reading and the result would be faxed to the surgery about 5.00pm the same day. This would be reviewed by a doctor almost immediately and the result was marked on a card which was then passed to the receptionist. The receptionist would telephone the patient to indicate whether the medication should be altered and when the next blood test would be taken (usually four or eight weeks).

I enclose a copy of the card used at the doctor's surgery with the relevant entry highlighted. The evidence given to me at the inquest was that an experienced doctor had reviewed the result of the INR test (2.44) and written the word "Same". By this he was intending that the previous prescription of 2mgs and 3mgs on alternate days should continue.

Unfortunately the capital "S" in the doctor's writing looks quite similar to a "5". The remainder of the word could be mistaken for the letters "mg". The receptionist who telephoned Mr A's home misinterpreted the writing as 5mg which was the instruction given to Mr A. That meant that the warfarin medication was effectively doubled. The error was not discovered for some three weeks until the doctor was called to see Mr A because he was unwell. To cut a long story short, Mr A died early the next day.

Examining the card on which the result was written, I was told that this was not a locally produced document and it was suggested that such cards are in very widespread use within the NHS. It seems to me therefore that any doctor who intends to write the word "Same" in similar circumstances runs a risk of an identical mistake depending on the style of their handwriting."

The new National Patient Safety Agency (www.npsa.org.uk) intends to undertake work to review the incidents of medication errors with anticoagulants. The Agency seeks to identify best practice and system solutions to improve their safe use later this year.

We ask all doctors to be aware of the potential harm that can result from illegible handwriting or the use of abbreviations. Diligence will save lives.

For further information please e-mail Gul Root at Gul.Root@doh.gsi.gov.uk

Methotrexate – inappropriate dosing and risk of pneumonitis

Following a number of medication errors, the Committee on Safety of Medicines (CSM) has recommended a change to the labelling of oral methotrexate products to include a new warning statement:

"Check dose and frequency – methotrexate is usually given once a week."

Revised packaging will be available shortly. In the meantime pharmacists are asked to be vigilant in ensuring that dispensing labels accurately reflect the intended dosage.

After increased number of reports of methotrexate-induced pneumonitis through the Yellow Card Scheme, CSM has advised that prescribers should:

- Inform patients of this risk and advise them to seek medical attention if symptoms (dyspnoea, dry non-productive cough and fever) develop;
- Monitor patients for symptoms at each visit;
- Withdraw methotrexate from, and administer corticosteroids to patients with, suspected methotrexate-induced pneumonitis.

Product information for prescribers and patients is being updated.

For further information please contact jan.macdonald@mca.gsi.gov.uk, Tel: 020 7273 0267 or julie.williams@mca.gsi.gov.uk, Tel: 020 7273 0269 at the Medicines Control Agency, Market Towers, 1 Nine Elms Lane, London SW8 5NQ.

Transfer of prison health to the Department of Health

As a natural development of the existing partnership between the Prison Service and NHS, it was announced in September 2002 that budgetary responsibility for all prison health services would transfer to the Department of Health from 1 April 2003. Responsibility will then be devolved to NHS Primary Care Trusts (PCTs) effectively mainstreaming prison based health care within the NHS. Full devolution of commissioning to PCTs in England will take place over the next 3–5 years. This shift will be preceded by collaborative work to draw out lessons for national implementation. The Welsh Assembly Government is still considering the implications of the transfer decision for Wales.

This transfer will increase the opportunities for GPs to work across the boundaries in the local community and within prisons. Many PCTs already employ GPs to work part of their week within prisons, whilst remaining a part of the PCT's clinical governance and professional responsibilities. There are also increasing opportunities for psychiatrists to work as part of multidisciplinary mental health in-reach teams.

Populations in prisons are generally young adults who on average stay for only a few months and often have substance misuse and mental health problems. This makes the opportunity to work with them within this relatively safe and stable environment invaluable prior to their return to the community. The partnership will also increase the opportunities for General Practitioners with Special Interests (GPwSIs) in areas such as substance misuse, mental health and genito-urinary medicine.

Further information is available on <http://www.doh.gov.uk/prisonhealth> or from jo.leech@doh.gsi.gov.uk

Paediatric and Congenital Cardiac Services Review

The report of the Paediatric and Congenital Cardiac Services (PCCS) Review Group was published on 21 November.

The Report:

- reaffirms the high standard of care provided by these services
- sets out the areas where they can be improved
- proposes a minimum number of operations each PCCS centre should perform in a year.

Comments are invited on all aspects of the report and particularly on the proposed number of operations where the evidence base is slight.

The full text of the Report and consultation letter can be found at <http://www.doh.gov.uk/childcardiac/>

Responses should be sent by 28 February 2003 to: pccrconsultation@doh.gsi.gov.uk or The PCCS Review, Room 512, Wellington House, 133–155 Waterloo Road, London, SE1 8UG

For further information please contact John.Rutherford@doh.gsi.gov.uk

Protocol-based care information pack

A tool to support NHS staff in developing protocol-based care has been prepared by the Modernisation Agency and National Institute for Clinical Excellence (NICE).

Developed around NICE guidance and other recognised standards, the new information pack is designed to help staff turn evidence into practice by addressing the key questions of what should be done, when, where, and by whom.

The pack aims to spread good practice and help professionals working in community, primary and secondary care by providing some practical guidance on how to develop protocols, linking this into the wider agenda for service modernisation, and providing useful information about other sources of advice, knowledge and support.

This pack is available at <http://www.modern.nhs.uk/protocolbasedcare>.

For further information contact anne.hackett@doh.gsi.gov.uk or telephone 020 7210 5469.

Hormone Replacement Therapy – safety information update

The recent publication of a major US study (Women's Health Initiative) of combined Hormone Replacement Therapy (HRT) has attracted considerable attention concerning its long-term safety. Details and estimates of the long-term risks and benefits of HRT are available in the latest *Current Problems in Pharmacovigilance* at <http://www.mca.gov.uk>.

Key new findings from the Committee on Safety of Medicines' review of these data are:

- Long-term HRT does not reduce coronary heart disease in women with or without previous history of cardiovascular disease and may increase its incidence slightly in early use. There is an increase in the risk of stroke in HRT users. The baseline risk of Venous Thromboembolism (VTE) in non-HRT users between the ages of 50 and 70 is higher than previously estimated, so the absolute risk associated with HRT is also higher.
- The known increased risk of breast cancer has been confirmed. Other studies have indicated a small increased risk of ovarian cancer in hysterectomised women with long-term use of oestrogen-only HRT. The risks of ovarian cancer with combined HRT are unclear.

Prescribers should be aware that:

- HRT should only be prescribed for the short-term relief of menopausal symptoms and prevention of osteoporosis and not for the prevention of cardiovascular disease.
- Due to the increased risk of some conditions with long term use of HRT (stroke, VTE, breast cancer and possibly ovarian cancer), the benefit-risk balance should be carefully considered for individual women planning long-term use of HRT for the prevention of osteoporosis, together with consideration of alternative therapies.
- The risk:benefit for ongoing treatment should be discussed with each woman at least annually.

HRT product information will be updated in line with the new safety information.

For more information contact: Dr Janet Nooney, Medicines Control Agency, 13–232, Market Towers, 1 Nine Elms Lane, London SW8 5NQ, Janet.Nooney@mca.gsi.gov.uk

Inhaled corticosteroids and adrenal suppression in children

Adrenal suppression is a well-established adverse reaction of all inhaled corticosteroids¹ particularly in children receiving higher than licensed doses of fluticasone. The MCA/CSM have recently reviewed this issue.^{2,3}

Adrenal suppression may be under-recognised. Prescribers are reminded that the presenting symptoms of adrenal suppression include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, decreased level of consciousness, hypoglycaemia and seizures. Situations which may trigger acute adrenal crisis include infection, trauma, surgery or any rapid reduction in dosage.

Prescribers are reminded:

- To review therapy regularly and titrate down to the lowest effective dose
- If a child's asthma is not controlled on the maximum licensed dose of their inhaled corticosteroid, despite the addition of other therapies, the child should be referred to a paediatric respiratory specialist.

For further information, please contact katharine.cheng@mca.gsi.gov.uk or 0207 273 0101

¹ CSM/MCA *Current Problems in Pharmacovigilance* 1998; 24: 8

² Drake A.J. et al. *BMJ* 2002; 324(7435): 1091–1083

³ Zahra S et al. *Arch Dis Child* 2002; 86 Suppl 1: A39

Levonelle/Levonelle-2 emergency contraception: new advice

Progestogen-only emergency contraceptive pills (ECPs) have been shown to be safer and more effective than the previously used Yuzpe method (oestrogen and progestogen). In the UK, Levonelle is a progestogen-only ECP that is licensed to prevent pregnancy when taken within 72 hours of unprotected intercourse. However, ECPs do not prevent 100% of pregnancies and are more effective the sooner they are taken after unprotected sex.

Table 1. Effect of Coitus-to-Treatment Interval on Efficacy of Levonelle (levonorgestrel 0.75mg)*

| Time taken after intercourse | Proportion of pregnancies prevented |
|------------------------------|-------------------------------------|
| 24 hours or less | 95% |
| 25–48 hours | 85% |
| 49–72 hours | 58% |

*Results from the WHO Task Force trial.

Twelve cases of ectopic pregnancy (out of a total of 201 unintended pregnancies) have been reported to the Committee on Safety of Medicines (CSM) following failure of Levonelle. Since pregnancies that occur in women taking progestogen-only pills (POPs) are more likely to be ectopic than those occurring in women who use other methods of contraception this is not unexpected.

The CSM has advised that:

- Women should be encouraged to seek treatment as early as possible after unprotected sex and advised that treatment failure may occur.
- Women who do not experience a normal period after using Levonelle should be followed up so that pregnancy can be excluded.
- The possibility of an ectopic pregnancy should be considered, particularly in women with a previous ectopic pregnancy, fallopian tube surgery or pelvic inflammatory disease.

For further information please contact Dr Jane Woolley at the MCA, jane.woolley@mca.gsi.gov.uk

GENERAL

The Public Health Link system

The Chief Medical Officer's urgent communication system to health professionals, otherwise known as the *Public Health Link*, has been modernised to take account of developing technologies and the changes within NHS organisations. Previously, Health Authorities were responsible for cascading to all health professionals. As Health Authorities no longer exist and Primary Care Trusts have been introduced, the cascade of urgent messages from the Department of Health has been updated.

Drug Alerts from the Medicines Control Agency (MCA)

The MCA is no longer disseminating drug alerts via fax to primary care level. The agency is now using the Public Health Link system to distribute them to Primary Care Trusts for onward cascade. The arrangements for distribution to NHS Hospital Trusts have not been changed.

The new system

A new website, headed *Public Health Link*, has been established which is accessible to everyone who has internet access. This will be linked to the Department of Health and Chief Medical Officer sites. The website will retain previous messages, and provide a searching facility. Its address is: <http://www.doh.gov.uk/publichealthlink>

When a new message is transmitted, as well as being placed on this new website it will simultaneously be e-mailed via the internet directly to:

- Regional Directors of Public Health
- Directors of Public Health (and nominated alternatives) of Primary Care Trusts and Strategic Health Authorities
- Medical Directors (and nominated alternatives) of NHS Trusts
- Others who have made a special case for receiving urgent messages

Categories of urgency

Messages will be labelled with one of the following categories:

- Immediate – for cascade in 6 hours
- Urgent – for cascade in 24 hours
- Non-urgent – for cascade in 48 hours
- For Information – not for cascade

The Public Health Link System *continued*

The Cascade system

Each new public health link message will make clear who is being e-mailed directly. Messages will also include details of cascade responsibilities.

NHS Trusts

Medical Directors will receive urgent communications directly on e-mail from the Department of Health. They will be responsible for cascading to health professionals working in the Trust such as: designated hospital doctors, clinical departments in the Trust, Nurse Executive Directors (who may be asked to forward to nurses and midwives), Trust Chief Pharmacists (who may be asked to forward to community services pharmacists).

Primary Care Trusts (PCTs)

Directors of Public Health in Primary Care Trusts or PCT type Care Trusts will receive relevant urgent communications directly on e-mail from the Department of Health. They will be responsible for cascading to health professionals in the PCT such as: Consultants in Communicable Disease Control, General Practitioners, Practice Nurses, PCT lead Nurses (who may be asked to forward to community nurses and health visitors), Chairs of PCTs, Chairs of Professional Executive Committees for PCTs, Leads at nurse-led PMS pilots, nurse leads in Walk in Centres, PCT Pharmaceutical Advisers (who may be asked to cascade to community pharmacists).

Directors of Public Health may be asked to cascade messages to private clinics as part of their public health responsibility for the local community. Some PCTs use shared agencies to cascade drug alerts to community pharmacists, GPs and private hospitals. Where this is the case, systems need to be in place to ensure that the information is cascaded to the Agencies.

Strategic Health Authorities (StHAs)

Medical Directors will receive urgent communications directly on e-mail from the Department of Health for information. They may be asked to cascade the message to Pharmaceutical Advisers and Lead Nurses in their StHA.

Others

Other authorised organisations and people will receive urgent communications directly on e-mail from the Department of Health where they have an important public health responsibility and are not likely to receive the message from any other source.

Contact details

Anyone with cascading responsibilities who wishes to receive public health link messages or drug alerts via e-mail but believes that the Department of Health does not already have his/her details, should contact icdb1@doh.gsi.gov.uk and ask to be added to the *public health link* mailing list. Title, name and initials, job title, job role (if different to job title), organisation name, workplace full postal address, email, fax and telephone details will be required. It is possible to request drug alerts only.

Directors of Public Health/Medical Directors of a StHAs/PCTs or NHS Trusts are already registered.

All messages will be approved by the Chief Medical Officer or a Deputy Chief Medical Officer before transmission.

*If you have any queries contact, Dr Eileen Smith,
104 Richmond House, 79 Whitehall, London SW1A 2NS:
eileen.smith@doh.gsi.gov.uk.*

For changes in address, please contact The Medical Mailing Company, PO Box 60, Loughborough LE11 0WP (or telephone Freephone 0800 626387).

CMO's Update is a newsletter sent by the Chief Medical Officer of the Department of Health to all doctors in England. It will incorporate some topics that might otherwise have required an individual letter, progress reports on earlier letters, and other information from the Department of Health that should be of interest to practising doctors.

CMO's Update is also available on the Internet at: www.doh.gov.uk/cmo © Crown copyright 2003.

Editorial address: 108 Richmond House, 79 Whitehall, London SW1A 2NS 29965 1p 122k January 03 (RIC)